Fall Risk Pre-Assessment Questionnaire Mail Out for Home Visits

Thank you for interest in learning more about preventing falls. Please complete this form before I come to visit you on _____. Please call me at _____ if you need to reschedule our appointment. Thank you, _____, Public Health Nurse.

1. When was the last time that you visited the doctor?_____
2. Reason?_____
3. Do you wear glasses? ..... ☐ Yes ☐ No
4. When was your last eye exam? _____
5. Do you have glaucoma? ..... ☐ Yes ☐ No
6. Other eye conditions? ..... ☐ Yes ☐ No
7. Do you wear hearing aids? ..... ☐ Yes ☐ No
8. When was the last hearing test? _____
9. Do you have any problems with balance? ..... ☐ Yes ☐ No
10. Do you get dizzy or lightheaded? ..... ☐ Yes ☐ No
11. If yes, how often?

    Every day ____ Every week____ More than 1 time per day ____
    Is this associated with getting out of bed or standing up?…… ☐ Yes ☐ No
12. Do you have problems with walking? ..... ☐ Yes ☐ No
13. Do you use a cane, walker, or wheel chair for assistance? ..... ☐ Yes ☐ No
14. If yes, which one? _____
15. Has the doctor ever told you are at risk for high blood pressure, or diabetes or other chronic illness?..... ☐ Yes ☐ No
16. If so, what conditions are you being treated for? _____
    _____
    _____
17. List the medications you take: _____
    _____
    Does this include medications for sleep/ nervousness/depression/seizures?..... ☐ Yes ☐ No
18. Do you have bowel/bladder or prostate problems? ..... ☐ Yes ☐ No

19. How many times do you get up at night to use the bathroom? _____

20. Do you feel sad, alone and helpless? ..... ☐ Yes ☐ No

21. Are you afraid you may have problems with your memory? ..... ☐ Yes ☐ No

22. Does it take you more than one try to rise from a chair or the toilet stool? ..... ☐ Yes ☐ No

Rising from chair. Please sit in your comfortable chair and tell us how many tries it takes you to raise to a standing position from that chair. _____

Environment:	**Yes**	**No**
1. Is there proper lighting in the home?	☐	☐
2. Are there stairs?	☐	☐
3. Are the stairs free from clutter?	☐	☐
4. Is there loose carpet or other obstacles on or around the stairs?	☐	☐
5. Are there handrails?	☐	☐
6. Are there multiple scatter rugs?	☐	☐
7. Are there cords or other obstacles in walkways and floor spaces that may cause falls?	☐	☐
8. Are there light switches at both ends of the stairs?	☐	☐
9. Can you turn on lights before entering the room?	☐	☐
10. When lying in bed is there a light within easy reach?	☐	☐
11. Are there night-lights in hallways, bedrooms and bathrooms?	☐	☐
12. Are there grab bars in the bathroom?	☐	☐
13. Are there abrasive strips in the shower or tub?	☐	☐

For more information:
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